

# **“MISSIONARY” REDEFINED: GERMAN MISSION WORK IN 21<sup>ST</sup>-CENTURY EAST AFRICA**

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## **Introduction**

While most of the world is witnessing steady improvement of social and economic living standards, vast areas of the African continent are ridden with deeply-entrenched problems, such as hunger, poverty, and the widespread presence of AIDS. One might expect that this is endemic of a continent that has had little exposure to the developed world, yet this is far from the truth; even the most remote village has been touched by the fingers of modernization and foreign influence. Several centuries of European colonialism, the continued exportation of Africa's valuable resources, and the ever-expanding presence of cultural and religious missions have all left their marks on African culture, and it has been well-documented that myriad new social, political, and economic problems and instabilities have been created as a result of this influx of foreign presence.

Today, economic development and humanitarian aid in Africa are more important in current worldwide political discussions than ever. Although much aid is currently being sent to Africa by large international organizations and NGOs, another important avenue through which this work is being done on a smaller scale is through Christian mission work, which can generally be classified into two categories. The first of these includes organizations that address the myriad social, economic, and political concerns facing Africans by improving access to healthcare or providing refuge for orphans, for example. The second group, while still employing similar methods of aid, differs from the first in that its primary goal is to communicate the message of the Christian church. By specifically teaching the local

population about the religion they are representing, church missions have an impact upon the local culture that sets them apart from their secular counterparts.

Mission work has undeniably checkered past, particularly in regard to the effect it has on indigenous cultures. Scholar and world-famous writer Ngugi wa Thiongo argues that culture gives a society its self-image and is “a repository of all the values that have been evolved by the different social strata in that society over time... Under ‘normal’ circumstances, a given society is able to absorb whatever it borrows from other contacts, digest it, and make it its own. But under conditions of external domination, conquest for instance, the changes are... forced upon it externally” (Wa Thiong’o xv-xvi). The drive to win converts for a particular faith is oftentimes seen as such a forceful change and is viewed by some as evidence of the persistence of neocolonialism (Fiedler 1). Similar critiques revolving around mission work and its capacity to strip a culture of its traditions and values began as early as the sixteenth century when Spanish Dominican priest Bartholemé de Las Casas (1484 – 1566) denounced the great injustices carried out against natives in the Americas under the banner of religion (MacNutt vii).

The discussion about the tension resulting from intercultural interaction is more relevant than ever; today the term “globalization” does not just refer to an opening or crossing of borders, but rather a transcendence of these physical and cultural boundary lines (Scholte). Interculturation and contextualization of religion are major issues in the missiological debate in Africa today (Fiedler xi). However, there seems to be an increasing trend in Christian missions to shy away from possibly overstepping these boundaries via proselytizing and to instead focus more on humanitarian aid and improving the physical conditions of Africans. Such a change could not be attributed solely to the goals of individual missionaries; rather, the role and influence of umbrella organizations that sponsor missionary work need to be considered in any analysis of the shift toward secularization of services.

Little data exists on how far removed is the reality of contemporary missions work from the patterns of the past and how this picture changes when analyzing the work of

missionaries from different countries. In East Africa, the region comprised of Kenya, Tanzania, and Uganda and the geographic area of focus for this study, German missionaries began founding mission posts as early as the mid-nineteenth century where they have had a continued presence aside from a brief hiatus after World War I (Pierard). The earliest German missionaries were school founders and church planters dedicated to modernization of infrastructure and education, especially in realms of literacy and religion, and in some cases to research, as many of them were also linguists. They hailed from all corners of the German-speaking areas of Europe and from many denominations.<sup>1</sup>

Although there is a large body of scholarly work about the historical presence of missionaries in East Africa, little has been published regarding current trends in German missions in this region. The main objective of this study is to make observations about the degree to which evangelization and humanitarian aid characterize contemporary Protestant German missions in East Africa since its beginnings in the mid-nineteenth century. It also seeks to determine the role that community-based work plays in determining which projects German Christian umbrella organizations will sponsor and how this affects intercultural interactions.

To gather data for my study, I spent six weeks researching in Kenya and Tanzania at two missions sponsored by the prominent German mission organizations *Christoffel Blindenmission* and *Allianz Mission*. Both have been in existence for at least a century and both are Christian-based organizations that are some of the largest of their kinds in Germany. I surveyed both the staff and members of the local community to determine how aware the local population is of the missions' ties to Christianity and their satisfaction with and reception of the mission projects. My data provides evidence that humanitarian aid and promoting community-based initiatives play a much greater role in German missions work

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<sup>1</sup> For a comprehensive overview of the presence of German missionaries in Tanganyika, see Marcia Wright's German Missions in Tanganyika 1891-1941: Lutherans and Moravians in the Southern Highlands. Oxford: Clarendon Press, 1971.

than evangelism. I also argue that these trends are reflected in the goals and guiding principles of the umbrella organizations, conventions clearly departing from past precedents of German mission work in this region.

### **Kwale District Eye Centre Results**

*Christoffel Blindenmission* (CBM) is one of the most important Christian mission organizations in Germany terms of size and scope of the projects it sponsors, global influence, and funding relative to other similar organizations. Founded in 1908 by Pastor Ernst Jakob Christoffel, what started as a home for blind orphans in Turkey has since grown into a powerful international umbrella organization that assisted 21.3 million people with disabilities in low and middle income countries in 2007 alone.

Although its initial goals were to focus on working toward the prevention and cure of blindness in developing countries, today CBM aims to educate and rehabilitate people with a wide range of physical and mental disabilities. CBM states that it is “an international Christian development organisation, committed to improving the quality of life of Persons with Disabilities in the poorest countries of the world. Based on its Christian values and over 100 years of professional expertise, CBM addresses poverty as a cause, and a consequence, of disability, and works in partnership to create a society for all” (“Mission Statement and Beliefs,” CBM International).

CBM sponsors 1005 projects in 113 countries, thirty-five of which are in Kenya and nineteen in Tanzania. One of those projects is the Kwale District Eye Centre (KDEC) in Mombasa, Kenya, which has been sponsored by CBM since 1996. Founded in 1993 by British ophthalmologist Dr. Helen E. Roberts, KDEC employs 53 staff members and serves an estimated population of about 600,000 stretching over four districts on the southern coast of Kenya: Kwale, Kinango, Msambweni, and Kilindini. The majority of this population lives below the poverty line; the primary sources of income are fishing and subsistence farming.

Most residents cannot afford necessary eye care, which KDEC, the primary eye care service provider for the district, seeks to provide to patients either free of charge or at a subsidized rate (Briesen 1).

Funding from CBM not only made possible a large addition to the small building facilities that the increasing volume of work quickly outgrew in its first years, but it also helps to subsidize a large portion of operations and the outreaches in local villages and towns. Without their support, it would be incredibly difficult for KDEC to continue doing work in the local community to the extent that they are now. Although initial donations from CBM far surpassed the monetary support that KDEC is currently receiving from the German mission, CBM still provides about 20% of KDEC's annual budget, a figure significant enough to explain KDEC's striving to meet annual benchmarks in community outreach and cataract operations performed (Dr. Helen Roberts, pers. comm., 6 Feb. 2009). Because CBM's sponsorship alone is not enough to fund the work of the clinic, KDEC has developed a variety of creative ways to generate funds locally, nationally, and internationally to increase financial independence from a singular source.

Of particular interest is the "Eye Give" charity shop that the Eye Centre operates in the nearby town of Diani Beach which attracts many tourists looking to buy souvenirs. The profits of all purchases directly benefit KDEC. Another example of securing monetary donations is the annual Diani Rules all-day athletic competition which many residents and businesses compete in and sponsor. In 2006, funds raised from the competition paid for 371 cataract operations (Diani Rules). KDEC has additional sponsors across the globe, including private donors and major charities like Sight Savers International, which in 2008 financed 22% of their annual operating costs.

CBM has established set criteria to decide whether or not to support a project. According to their website, the basic requirements are that support must be needed, assistance must be wanted by the local community, and able partners must exist to run the programs.

The organization has also published essential working standards for their partner projects which include local capacity building through human resource development and training of members of the community, the provision of rehabilitation services via community-based programs, and prioritizing the accessibility of services to very poor people (“Capacity Building and Sustainability,” CBM International). KDEC seeks to meet these standards primarily through the implementation and growth of their Community-Based Programme (CBP) designed to understand and meet the eye care needs of the local population. Additionally, the vast majority of staff employed by the Eye Centre and their volunteers are native Kenyans, which promotes organizational sustainability, especially if Dr. Roberts should ever need to take a sustained leave of absence from the clinic.

It is also noted that although serving the “poorest of the poor” does not allow for cost recovery, “the programmes should have a sound financial vision and aim at decreasing financial dependency and increasing organisational sustainability” despite the ability of the local population to finance all services and overhead costs provided by partner projects (Ibid). This principle is a part of CBM’s commitment to enable its partner organizations to gradually become independent from international assistance. Evidence of this can be found in their fiscal policy that dictates an approximate annual 20% decrease in monetary support to partner organizations (Dr. Helen Roberts, pers. comm., 6 Feb. 2009). KDEC’s compliance with this principle is seen in its myriad forms of generating income both locally and abroad through private, corporate, and charitable sponsorship.

Noticeably absent from the list of requirements for CBM sponsorship is any mention of religion. There are no implications of proselytizing being a necessary component of potential partner projects. Not only is talk of evangelism absent, but so are doctrinal statements that are commonly found on the websites of many other missions organizations, and Christianity is with a few exceptions almost invisible within the boundaries CBM’s website. Even the name of the organization is free from religious connotations or undertones;

initially called “Christian Mission to the Blind,” the new name of *Christoffel Blindenmission* was adopted in 1956 to honor the mission’s founder, Ernst Jakob Christoffel, after his death in 1955.

The leadership structure of CBM is also changing; in earlier years, CBM presidents were generally former pastors like the organization’s founder. However, in 2006 CBM elected a new president, Professor Dr. Allen Foster, a highly-qualified eye surgeon without previous experience working as a pastor. Regarding the work that CBM does in light of its connections to Christianity, Foster states that “exclusion can be on the basis of nationality, faith, gender, and age, just to name a few. The role for CBM was to follow the teachings of Jesus who was inclusive... Jesus had a particular heart for the poorest in society. But people with disabilities are the poorest of the poor, not just in financial terms but in their quality of life. They have little voice” (Lopez).

He intends to address what he identifies as two major barriers to the ministry that CBM engages in by including more people with disabilities in senior decision-making and by focusing on becoming a “truly international Christian development and disability organisation. We work in many countries but I am not sure we have equal opportunities for people from all nationalities to work with us. Rather we tend to be Anglo-Saxon Protestant in our funding country offices” (Ibid). CBM’s dedication to ethnic and religious diversification of leadership is reflected in the human resource policies and management structures of its partner projects. KDEC is a prime example of an organization committed to including an ethnically and religiously diverse group of people serve in key leadership roles.

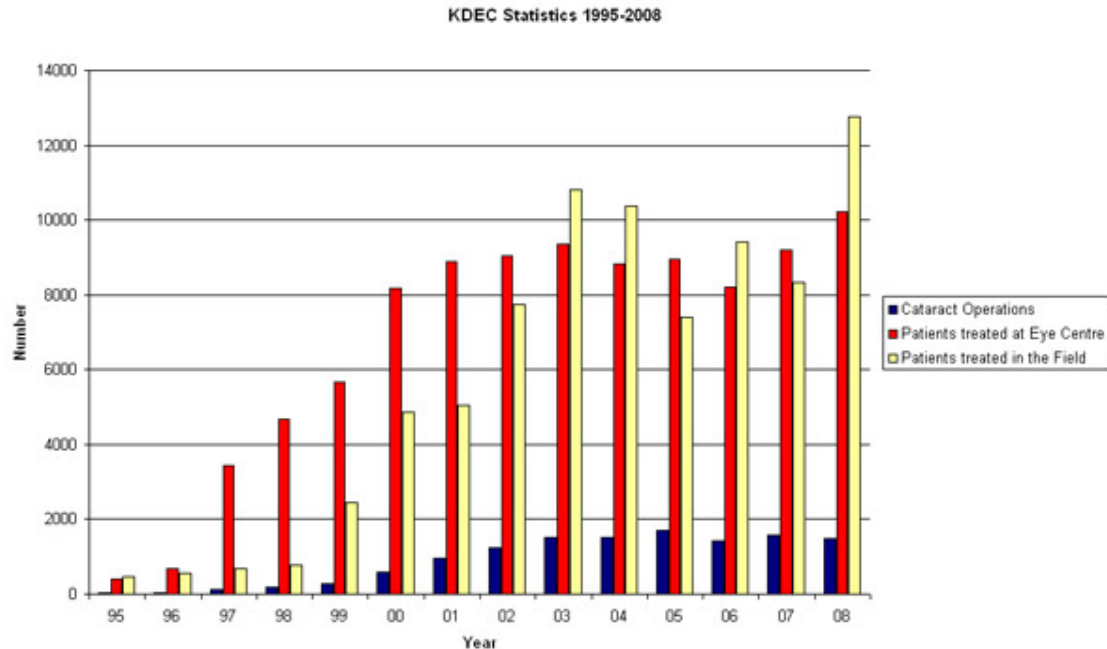
KDEC is currently operating with a great deal of success in terms of number of operations performed and is progressing towards organizational sustainability while meeting annual benchmarks set by CBM. However, when it first opened its doors in 1993, the clinic struggled to find patients who were willing to undergo treatment; despite the availability of quality eye care at little to no cost, the Eye Centre has encountered major obstacles that have

had to be overcome to find patients from the surrounding villages. KDEC has identified these barriers as fear, lack of knowledge, poverty, gender, and traditional values. For example, many people were afraid that the people working in the eye hospital had come not to help people see, but rather to sell people's eyes in Europe and to replace the lost eyes with those of a goat.

Another impediment that prevented community members from coming to the clinic for treatment is the local importance of traditional medicine that is usually received from *waganga*, the Swahili term by which traditional healers are addressed. They are often trusted and sought out before modern medicine for the treatment of myriad medical problems. Although *waganga* cannot treat some of the more common forms of eye conditions such as cataracts and glaucoma, before KDEC was founded, there were no real alternatives to natural medicine. The mostly rural population cannot afford to travel to a larger city to pay for eye treatment in a hospital, nor is it easy for a people unfamiliar with modern medicine to accept such a clinic without some form of cultural mediation or trust-building.

For four years KDEC performed relatively few operations and screenings until the implementation of the Community-Based Programme (CBP) in 1994, which over time has drastically changed the way the community views the Eye Centre because of its role in increasing active engagement with and education of the community about eye care. As the CBP began to grow with a staff of volunteers called Community Based Workers (CBWs) from the surrounding towns and villages, there was a marked increase in patients, in community awareness about eye health, and in eye operations at KDEC.





Number of patients treated at the centre, number of patients treated in the field by outreach clinics, and the number of cataract operations carried out for the years 1995 to 2008 (“Statistics,” Eyes for East Africa).

The CBP works to empower the community through its various programs which are organized into four distinct areas: eye care, education for the visually impaired, rehabilitation of the blind, and deaf blind people rehabilitation. The foundation of the CBP is its staff of eleven CBWs who are members of the local villages and towns in which they create awareness about eye health, coordinate outreach clinics, and perform door-to-door pre-screening to identify patients with eye problems or deaf blindness. This new way of relating to the community can also be seen in the alteration of KDEC’s mission statement, which in 1993 was “to bring affordable accessible eye care to the people of Kwale District,” and was changed in 2000 to read “empowerment of the community through provision of affordable accessible eye care.”

Through interviews with many of the CBWs employed by KDEC, it quickly became apparent that they take pride in the work they do; many underscored the necessity of their presence in the surrounding communities in raising awareness about eye health, and several

told me that they did not believe the clinic could function without them. Evidence for the staff's prioritization of being a community-based organization is seen in the responses of all but one staff member who said that it was "very important" for KDEC to work with and train local members of the community. This was made especially clear to me after talking with many CBWs who talked about having a personal sense of deep involvement and investment in their communities through their participation in the CBP.

The CBP works with existing community structures at the village level such as village health committees, women's groups, and traditional healers who are trained in basic eye health. These groups work with CBWs to educate community members on comprehensive eye services offered at KDEC and can identify and refer patients to the clinic. The CBP also partners with the Ministry of Health (MoH) of Kenya's District Health Management Team to provide eye care services, and patients identified by the MoH who have cataracts or glaucoma are referred to KDEC for surgery. Further collaboration with the MoH has allowed KDEC to participate in the establishment of annual health plans for the four districts in which they operate and to hold joint health action days. The Eye Centre also cooperates with the Ministry of Education to facilitate the provision of education services for visually impaired children, especially those who have been integrated into the mainstream education system and require appropriate low vision devices such as Braille machines and papers. CBWs also follow up with these children and their teachers to ensure that optimal education is being provided.

Although KDEC recognizes that collaboration with Kenyan government agencies is an important part of their efforts to work with existing community structures, the CBP's utilization of staff and volunteers from the surrounding villages cannot be replaced by involvement with the MoH. One major reason for this is that the majority of MoH workers are from up-country areas, and although linguistic and religious differences between them and residents of the Kwale District generally do not cause conflicts, the differential level of education and unfamiliarity with local culture often makes communication difficult (Berman

6). Because of these difficulties, CBWs are still an essential and irreplaceable part of KDEC's involvement with the local population.

Rehabilitation of the blind is another important service offered as a part of the CBP. Rehabilitation officers undertake necessary intervention with low vision patients, especially those who are irreversibly blind, and their family members who are identified by CBWs, which often consists of training in daily living skills such as orientation and mobility. These skills help patients to lead independent, productive, and dignified lives as socially included parts of their communities, and many are even trained in income-generating skills such as keeping a small shop or raising chickens. KDEC alone could not facilitate the great success that this portion of the CBP has seen; instead, cooperation with existing community structures and members is essential for its ability to affect real changes in the lives of low vision patients.

The CBP seeks to work with rather than against existing cultural standards. For example, rather than discrediting the work of traditional healers, the CBP has taught many of these respected members of their villages about identifying medical conditions which they can or cannot treat and encourage them to refer patients with eye conditions to KDEC. The CBWs also work with the doctors and nurses at the clinic to help them better understand the fears that people have of surgery and how to best approach the topic of having an operation. One way in which this is done is to avoid using the Kiswahili word for "surgery" when talking to patients, which can have very negative connotations and cause great apprehension because its meaning is not understood, instead referring to eye operations as "cleaning" the eyes.

The Eye Centre effectively uses and works with the surrounding communities to such a great degree that it has over the past sixteen years become a well-known and generally well-respected part of the nearby towns and villages. I spoke with several women during one visit to a remote village in the Kinango region who had been referred by their village chief to come to an eye screening, and I was even able to interview a traditional healer, or *mganga*, who

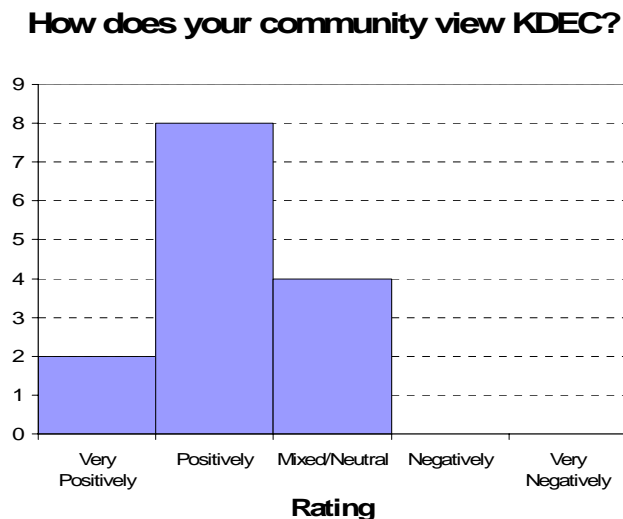
came to have her eyes checked. This attests to the fact that there is a great deal of trust that has been built up over time between the Eye Centre and local communities because of support by traditional leadership. Additionally, the great increase in patients and in operations performed since the clinic's beginnings in 1993 provide further evidence that KDEC has become an important part of the four districts it serves.

I interviewed fourteen members of the community that is served by KDEC who had some form of interaction with or knowledge of the Eye Centre. Most were existing patients, but four were either new patients or had just come to an eye screening in the field. Interviews at the Eye Centre were conducted in a private room with myself, a translator, and the participant present. In the field I spoke with participants in a secluded setting, and again the only other party present was the translator I used. Because I wanted to gain a balanced perspective on the community's impressions of and beliefs about KDEC, I conducted interviews in both English and in Kiswahili through a translator when the person being interviewed could not speak English. This ensured a mixed sampling of levels of education in the people I spoke with. Nine interviews were held in a private room at the main facilities of KDEC, while five were held at an eye screening in a remote village an hour's drive from the clinic. This was also designed so that I would be able to talk with people with a mixed sampling of impressions about the Eye Centre, as those who actually make the trip to the clinic have already indicated that they trust the eye care services and staff to a greater extent than someone who comes to a village screening.

In general, those interviewed had a positive impression of KDEC and the services they provide. All ten existing patients said that their experience with treatment from KDEC was either "very good" or "good" and responded positively when asked whether or not they would recommend the services of KDEC to a family member or friend. Eight of those interviewed said that their community viewed the Eye Centre "positively," two responded with "very positively," and four gave a "mixed or neutral" rating. Of those who responded with

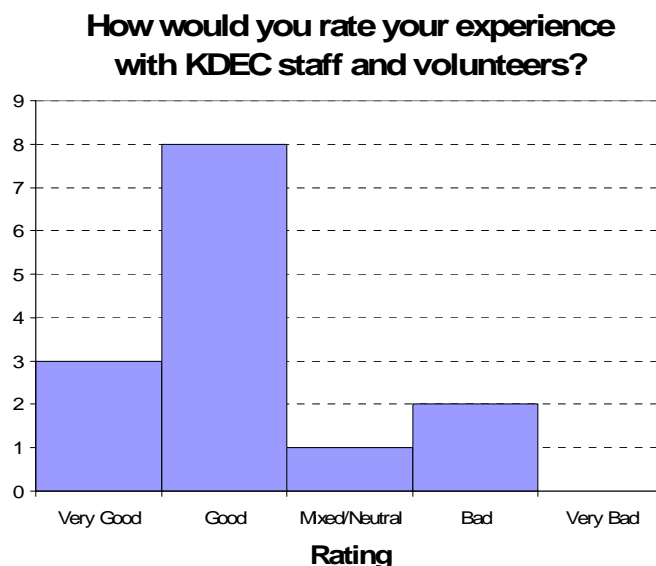
“mixed/neutral,” three were interviewed during the eye screening in Kinango and had less contact with KDEC and its staff members than those who I interviewed at the clinic, and two of them were new patients.

No one said that their community viewed the Eye Centre “negatively” or “very negatively,” and those who spoke English were generally more optimistic about community perception than those who could not. This difference in responses is likely due to the fact that speaking English is an indicator of having a higher level of education, which generally signals a higher socio-economic status and fewer cultural barriers that must be overcome to trust modern medicine in these individuals. Despite this difference, it is still very significant that the majority of responses were positive, especially because of the extremely negative and suspicious perception of KDEC that staff members reported initially encountering in its first years.



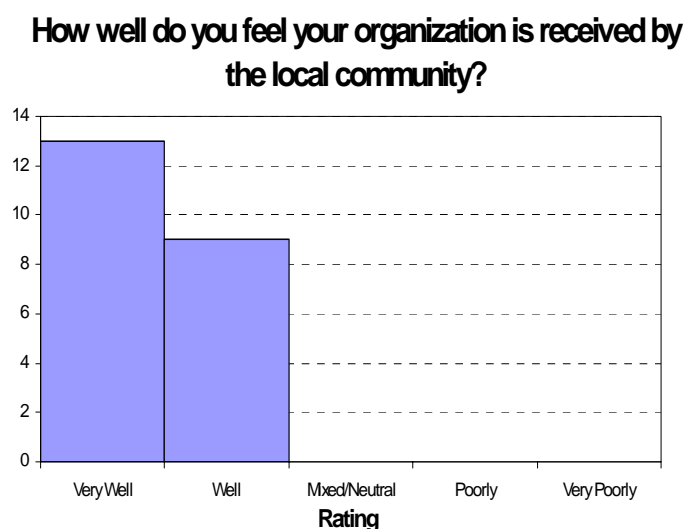
Of those who were existing patients at KDEC, 100% said that they would rate experience with the treatment they received as “good” or “very good.” When I asked specifically about interactions with the staff and volunteers working with KDEC, the results were similar. Two outliers in this data came from new patients I spoke with at a screening in their village, both of whom rated their experiences with the volunteers negatively and whose

first contact with KDEC staff came during the screening that day. The reasoning for their disapproval was because they felt that the volunteers had not done an adequate job at getting the word out to community members about the screening. The responses of these two women indicate that they feel the services offered by KDEC are valuable and that they would like to be informed about future screenings or other awareness meetings in their area.



However, in this particular instance, the women interviewed had heard about the screening from their village chief, which provides evidence that the CBW assigned to this region had in fact been in contact with the leadership of the village to inform potential patients of the event. In fact, judging from the results of my survey, it would appear that information about KDEC normally spreads by word of mouth, a logical outworking of the fact that Kenyan culture is steeped in a history of rich oral tradition (Gatheru 70). This process is set into motion when CBWs announce the events ahead of time by informing the village health committee of an upcoming screening or awareness meeting. 9 of 14 respondents said that they first heard about KDEC from a community member, 3 from family members or friends, and one person received a medical referral from a hospital in Mombasa. No one reported receiving information about the Eye Centre initially from staff members or from other forms of advertisement.

When I asked members of KDEC's staff about how their organization was received by the local community, the results I got were slightly more positive than the ratings given by patients. 59% of staff members said that they felt that KDEC was received "very well" by the local community. The other 41% responded that their organization was received "well." There was not a significant difference in responses to this question between staff members who work exclusively in the clinic and those who work primarily in the field. Of new and existing patients surveyed, however, 57% answered the same question with "well," 29% with "mixed/neutral," and only 14% said that KDEC was "very well" received by the surrounding population.



Because KDEC employs a staff that is almost entirely Kenyan, I was only able to interview two non-Kenyans, one of whom is the medical director and the other an ophthalmologist at the Eye Centre. Both said they thought the clinic was "very well" received by the surrounding population, which is quite different from the 14% of members of the local communities who gave the same response. However, because the sample size of non-Kenyans was so small in this survey, accurate conclusions cannot be drawn from this data to provide evidence for or against foreigners being cognizant of and in touch with local opinion,

especially concerning charitable work provided by foreigners. My study also does not account for cultural conventions regarding how praise is expressed in this region, another factor that could play a role in why participants answered in a certain way. It can be stated, however, that because 51 of 53 employees at KDEC are Kenyan, the chances of the staff being well-informed about local customs and opinions is much greater than if the majority of the staff was comprised of foreigners new to Kenya and the local tribes and districts.

I also asked staff members and patients questions about religion to attempt to discern what kind of influence the gospel of Christianity has in the clinic and what religious messages might be conveyed to patients as a result of a portion of KDEC's funding being donated by the Christian mission organization CBM. Of the fourteen new or existing patients that I interviewed, ten identified themselves as followers of the Muslim faith, and four were professing Christians. When asked if they knew any groups or organizations that sponsored the work done at KDEC, only five responded positively. Of those five, just one told me that she knew Christians financially supported the work of the Eye Centre. The other four responses included assertions that their sponsors were "well-wishers", Muslims, private donors, and "rich foreigners."

Next I asked patients which religious group they would guess was one of KDEC's biggest sponsors. Four people said that Muslims were probably the biggest sponsor, six guessed Christians, three named other non-religious groups, and one person did not respond. Of the six who said Christians funded a portion of the clinic's work, only two of those responses were given by Christians. My data is supported by my experiences observing work done both in the clinic and during two visits to the field for eye screenings, because during my three-week stay, I never once heard Christianity being discussed with patients. There was also no outward sign of religious affiliation within the walls of the clinic itself; no religious articles or sayings were to be found. This is additionally substantiated by information gathered during an interview with Dr. Roberts, who said that she would prefer that staff members not discuss

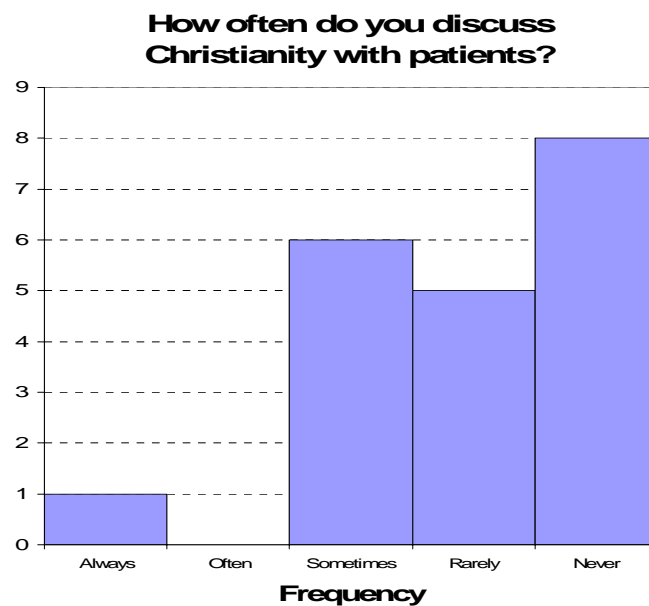


religion with patients because she does not want to alienate the primarily Muslim population on the coast that KDEC serves.

Further evidence to support the patients' lack of knowledge about Christian funding of subsidized surgeries is found in a recent study by Dr. Sebastian Briesen at KDEC which found that sixty percent of patients did not know who sponsored surgeries, and very few ever raised questions about funding. In this study, all participants were asked who the main sponsor of their surgery was. They were given a list of six possible options from which to choose. 54% of those surveyed answered that the Kenyan government was the principle donor, while 0% responded with Christian organizations. The rest of the responses were divided between KDEC (12%), Dr. Helen Roberts (12%), rich people from foreign countries (22%), and Islamic organizations (0.01%). The majority of these responses do not accurately identify sources that actually provide funding for KDEC (Briesen 5).

The fact that in my study a disproportionately large number of community members guessed that Christians sponsored work at KDEC in comparison with the actual number of Christians interviewed can be explained in part by the fact that many Kenyans living on the coast have the impression that the vast majority Europeans are Christians, probably stemming from a long history of missionary work and colonialization by Europeans whose major religion was predominantly Christian (Dr. Helen Roberts, pers. comm., 6 Feb. 2009). The results of my study could also be skewed because I was present during all interviews, perhaps influencing people to respond with an answer they thought that I as a Westerner might want to hear. Because Dr. Roberts is British, they may assume that the clinic is Christian-based. Dr. Roberts even reported hearing complaints from within the surrounding communities that she only hired Christians to work at the clinic, a claim that is obviously false; of the twenty-two staff members I interviewed, only half professed to be Christian, and several members of staff wear clothing that signifies being a member of the Muslim community.

When I asked staff members whether or not they felt that KDEC was a Christian organization, however, nine of twenty-two responded with “yes.” Fifteen people, all of whom spent the majority of their time in the field, said that they normally inform patients receiving sponsored treatment that a portion of the money comes from a Christian organization. However, this data is not supported by the results of my interviews with community members who were unaware of the source of financial backing by Christians. On average, staff members told me that they rarely discussed Christianity with patients KDEC serves, and of those discussions, they were generally only occasionally initiated by the staff member him- or herself.



Because of these results, I was led to believe that staff members and CBWs do not generally publicize their ties to a religious group. I doubt the accuracy of the responses of those who told me they inform patients that sponsored treatment is paid for in part by a Christian organization; some CBWs were certainly suspicious that I would report my findings to CBM if they did not respond correctly and did not want to jeopardize future funding.

I also asked employees working primarily in the clinic whether or not religion played a role in their decision to work in the Eye Centre; only one of nine responded that it did.

Perhaps the most interesting part of these interviews with staff members was hearing their answers about whether or not they felt discussing religion with patients is or would be beneficial to KDEC's work. 63% said that it would be beneficial to the organization. The explanations for this response varied but included:

“It would treat them spiritually, which promotes healing.”

“Would reinforce in patients the idea that this organization has a belief in some supernatural power - who is the healer - It would enlighten them on where the donations come from.”

“They would at least know where the money comes from; They might realize that Christians often do good and in a charitable way; To help spreading Jesus' words.”

“The patients will believe that the clinical treats and God heals.”

“It will make the patient more comfortable and it also improves patient confidence.”

Among the answers for a dissenting opinion were remarks that conveyed the concern that because the majority of patients are Muslim, discussion of religion and specifically Christianity might alienate people. The medical director added that the mission of KDEC is to empower the community, not to evangelize or convert people. The results between those answering “no” to this question correlated exactly with those who did not identify themselves as Christians; it was exclusively professing Christians who thought religion should be discussed with patients.

Opinions on the subject of religion appear to have had no effect on hiring staff members at KDEC; in fact, Dr. Roberts told me that she views religion as divisive and prefers that it not be openly discussed in the clinic in an attempt to prevent internal divisions among the staff. Interestingly, this appears to have had no adverse effect on obtaining funding from CBM despite the fact that the two organizations do not share a common view of religion.

## Geita Resource Center Results

Another well-established and long-standing German Christian mission organization I chose to research is the *Allianz Mission* (AM). Founded in 1889, AM is one of the largest German missions and has 125 missionaries working in twenty-one countries worldwide to date. The mission's foundational vision is to make Jesus known to all people in all walks of life as the healer and savior of the world ("Missionsverständnis der AM," Allianz Mission). In addition to meeting spiritual needs of the populations AM missionaries work with, the projects they sponsor are also designed to treat each person as an individual and to meet social and physical needs as well.

As stated on their website, AM holds fast to the conviction that evangelism and social work are inseparable and thus sponsors outreach efforts that confront poverty and which build up the infrastructure of local communities, especially in education and healthcare. These services are provided regardless of race, religion, gender, or socioeconomic status ("Projekte," Allianz Mission). While the focus of AM missionaries in the past was on church planting and founding Bible colleges, today the approach is much more holistic and is aimed at meeting the needs of the whole person, not just spiritual needs (Daniel Kroppach, pers. comm., 26 Feb. 2009). AM remains in principle a church-planting mission organization, yet it has recently begun to include more projects centered on developmental and humanitarian aid, especially in countries where there are already many Christian churches. The organization places great value on projects that promote cultural relevance and that employ and equip leaders from within the local community as early as possible ("Wir stellen uns vor," Allianz Mission).

AM sponsors several projects in East Africa: one is located in Kenya, and six are in Tanzania. One of these projects is the Geita Resource Center (GRC) in Geita, Tanzania which I researched for my second case study. GRC operates under the leadership of Daniel and Steffi Kroppach. Originally from Cologne, Germany, Daniel and Steffi moved to Geita in 2006 to continue building up the programs associated with GRC, a project which had began

nearly a decade ago and was left abandoned shortly thereafter when the previous AM missionaries left the region.

Located twenty kilometers south of Lake Victoria in Tanzania, Geita was originally founded as a German gold mine town during the colonial period. Mining in this area was banned by the government until approximately fifteen years ago when the Tanzanian government reopened it to foreign mining companies. There is no accurate census data to determine the population size, but the town has grown exponentially since open pit gold mining began again in the early 1990's (Daniel Kroppach, pers. comm., 26 Feb. 2009). Religion in Geita is comprised predominantly of indigenous religions and Christianity under the headship of the African Inland Church (AIC), and there is some Muslim influence in the area, but to a lesser extent than the other two religious groups (Ibid). Although the economic conditions for the average resident of Geita are significantly better than in the more remote areas of Tanzania because the gold mines provide jobs, the ability to obtain enough food, clean drinking water, and adequate medical care are still struggles for many, if not most, Geitans.

When Daniel and Steffi Kroppach arrived in Geita, the extensive physical facilities of the GRC were in tact but were not being used as there were no personnel to run programs. Although they had a large building originally planned to be used as a vocational training center that is well-equipped with welding and woodworking machinery, a lorry for transporting materials, classrooms, offices, and acres of land, the Resource Center had been unused since 2001. Rather than serving its purpose of bringing resources to the community, specifically to those who would benefit from being able to use the equipment to produce or manufacture income-generating products, the GRC was instead costing AM tens of thousands of dollars in annual maintenance and security costs that did not benefit the residents of Geita as intended. This phenomenon of unsustainability of projects is common in missionary work; oftentimes when missionaries leave a region, the projects and programs that they pioneer in

the local communities stop functioning shortly after their departure because no indigenous leadership has been trained to continue the work.

The Kroppachs plan to use the GRC as a central hub for providing resources to further personal income-generating projects of local community members. In order to encourage and publicize the availability of their facilities, the Kroppach family is working in partnership with and under the umbrella of the AIC in the youth department to build up self help groups (SHGs) in villages surrounding Geita. According to the *Deutsche Arbeitsgemeinschaft Selbsthilfegruppen*, a German organization dedicated to the support of these groups, SHGs are defined as “voluntary associations of people whose activities are aimed at overcoming shared illnesses or emotional or social problems that affect the group’s members” (“Selbsthilfegruppen,” NAKOS). Facilitating these groups is an increasingly popular concept that is employed worldwide. *Kindernothilfe* (KNH), for example, is a well-known German NGO that has established SHGs in developing countries with notable success (“Hoffnung für die Ärmsten,” *Kindernothilfe*). The Kroppachs will model their groups after the approach used by KNH called the self help concept, which is based upon two major principles:

1. Every human being has tremendous, God-given potential. This hidden potential in the poor can be unleashed if the right environment is provided. Society has pushed certain sections of her people to the Margin saying that they are ‘No good’. These vulnerable and marginalised sections slowly accept and internalize the state they are thrown into. The SHG process helps them question this state and come out of it step by step.
2. As an individual the poor are voiceless, powerless and vulnerable. By bringing them together as a homogenous collective aware of their rights, they have tremendous strength. The SHG approach is all about rebuilding strong and homogenous communities thereby bringing people together and empowering

them. 'Value systems' that were broken and abandoned are systematically restored in the community ("The Self Help Concept," Kindernothilfe).

Until very recently, the Kroppach's time has been primarily spent on building a house for their family and familiarizing themselves with Swahili and with the local community and culture. However, within the next few months, they hope to be able to form five SHGs in some of the villages surrounding Geita. The typical group will consist of about twenty of the poorest residents of each community who will be identified by the village elder or chief. These people will then meet once a week to identify problems in their community and to brainstorm feasible steps that they can take together to work towards solutions. The issues they identify can be as small as needing minor home repairs or as major as wanting to create a way to provide food or medical services for fellow villages.

The expectation is that the initial ability of the group to be able to affect changes will be relatively small at the beginning, but that as the group solidifies and as they learn to work together and develop a strong sense of community amongst themselves, their impact will grow. Mr. and Mrs. Kroppach related stories to me of SHGs that they have seen in which members started out by saving a small amount of money each week that eventually paid for a few chickens. The group then raised chicks from their chickens, sold eggs, and saved the money to buy a goat. Sometimes groups are able to raise enough capital and manpower that they can even loan community members money or help construct entire homes ("Case Studies," Kindernothilfe). Eventually momentum can pick up as members begin to see that their working together actually allows them to be more in control of their life circumstances, and they build upon past successes to generate an even greater capacity for change. One example of the impact such groups can have long term is the political parties that arose in India out of what originated as a small SHG (Daniel Kroppach, pers. comm., 26 Feb. 2009).

While I was staying with their family, the Kroppachs took the first step towards building up the SHG project by hiring a woman from the local community who will be the area director for this program. She will be trained by the Kroppachs on how to initiate contact with village elders and how to facilitate group sessions without exercising too much control in order to allow group members to create their own structure and expectations for how the group should function. The hope is that as these programs grow, representatives from each group will be able to meet together to exchange ideas discuss successes and problems. Eventually, the Kroppachs hope that these representatives will in turn help to start other SHGs in nearby villages, creating an entire network of people dedicated to improving their lives and working together within the structure of their own communities.

The decision to hire an area director and to focus on raising up leadership from within the native population is essential to the sustainability and success of any project started by foreigners; the Kroppachs believe that being community-based in structure and leadership will foster a sense of trust between villagers and those planning events and programs. This is also a reason for involving village elders in choosing group members. Another measure that they hope to take to foster sustainability of the project, especially during their one-year furlough after each four-year term in Tanzania, is to generate enough income from renting the equipment at the GRC that it will be able to sustain itself without needing additional monies from AM. This is, however, a long-term goal that cannot be met until there are multiple SHGs operating in the area that will utilize the Resource Center.

In addition to the focus on building up SHGs, the Kroppachs have found themselves being active members of the community in Geita and providing aid in many other ways. For example, Mr. Kroppach has worked with a local builder of the small coal-fueled stoves that the vast majority of Tanzanians cook over to make them more fuel-efficient by making a few simple design changes. He then helps to instruct consumers of this product on how to best use it to get optimal heat with a minimum of coal, a relatively expensive resource for most



residents. The Kroppachs also help to facilitate seminars led by speakers or volunteers from Europe or America in the local villages. During my stay, two Americans working with *Maisha na Maji* (Swahili name for “Living Water”) held seminars about avoiding disease through practicing good hygiene and drinking safe water for one week in villages identified by the Kroppachs.

Another significant role they play in the community is as an employer; between security guards for their home and for the GRC building, household staff, gardeners, and now the area director of the SHG program, the Kroppachs provide jobs for ten people. Hiring villagers is an expectation of foreigners living in this area of Tanzania, and it contributes to the local economy, even if in a small way (Stefanie Kroppach, pers. comm., 13 Feb. 2009). The Kroppachs are also affecting the economy in a small way through Mr. Kroppach’s experimenting with his gardeners with cultivating plants that are unusual for the Geita area such as vanilla, horseradish, cauliflower, and broccoli. This is an attempt to diversify markets flooded with identical produce and wares sold by each vendor. Their goal is to successfully cultivate these foods in order to be able to teach others how to plant and sell them at the local markets for which there already appears to be a potentially large demand.

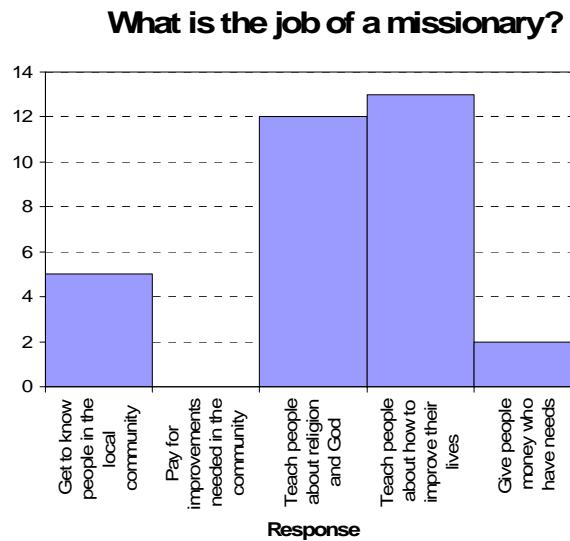
During my two-week visit in Geita, I interviewed fifteen members of the local community to shed light on what impressions they have of missionary work. Of these interviews, about half were conducted in English and the other half in Swahili in an attempt to survey people with a broad range of educational backgrounds. The interviews conducted in Swahili were translated by a woman who worked for AIC with previous experience in translation and who was recommended to me by the Kroppachs as someone who would be able to reliably and accurately relate my questions and the answers of the participants. The range of employment of participants also varied widely; I was able to interview the diocese bishop and several other diocese officials as well as gardeners and housekeepers. Most people I spoke with were paid for their work by the church, and all professed to be Christians. For the

most part, potential participants were identified by my translator because she was familiar with many AIC employees who also know Daniel and Steffi Kroppach. All interviews were conducted in a private setting with myself, my translator, and the participant on church grounds, which includes the church building itself as well as the land the Kroppach family lives on.

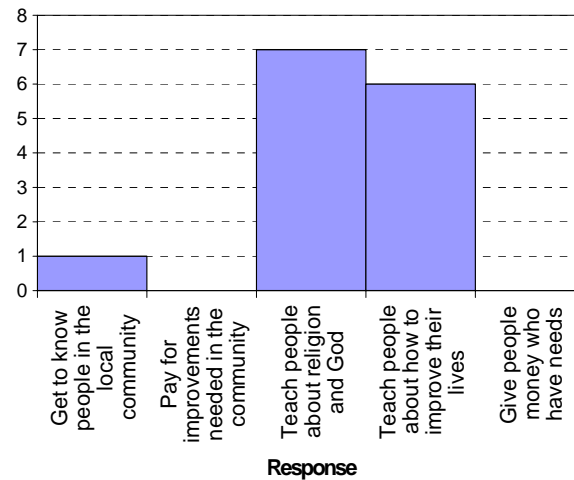
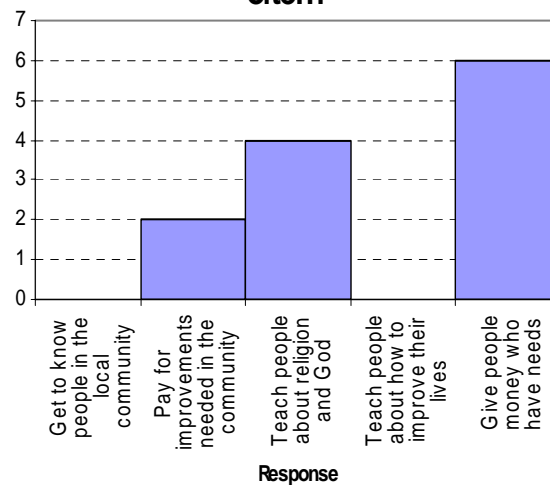
It is important to note that in the past decade, the only long-term missionaries working in this geographic area have been Germans sent by AM. Currently the only missionaries in Geita are the Kroppachs and one other woman who specializes in natural medicine and ministry to people who are HIV-positive, so the views expressed by those I interviewed do not necessarily reflect only on the mission of the Kroppachs and on GRC. Furthermore, many of the people I interviewed have moved to Geita within the past five to ten years and may have had contact with other missionaries in different regions of Tanzania. However, each of the fifteen people I interviewed had at least bi-monthly or weekly contact with either the Kroppachs or with the other AM missionary working in Geita.

The first question I asked was for each person to define what they believed a missionary was. Responses were generally quite similar; each answer contained two components: a missionary is someone who comes from a foreign place or culture, and they preach the gospel. Some people elaborated to refer to missionaries as “God’s ambassadors” or “messengers” and a few spoke of missionaries helping others. When I asked them to select from a list of options what the job of a missionary was, however, responses varied to a greater extent. They were allowed to select as many options as they thought applied. No one answered that paying for improvements in the community was a part of their job, although two said that giving people money who have needs is a component of missionary work. Five people answered that getting to know people in the local community is the job of a missionary. The most popular answers were “Teaching people about religion and God” and

“Teaching people how to improve their lives or community” with twelve and thirteen responses respectively.



When presented with the same choices and asked to identify which were done most and least frequently by missionaries, results were similar; the majority of people said with nearly equal frequency that teaching the local population about God and about how to improve their lives or community were the most commonly-performed tasks. Interestingly, four people answered that one of the tasks they saw missionaries engaging in the least often was teaching about religion. Eight people said that missionaries are least likely to either pay for improvements in the local community or to give money to people who have needs.

**What do missionaries do most often?****What do missionaries do least often?**

During the course of answering these questions, several people expressed frustration at their inability to definitely say what a missionary does. These people generally conveyed a sense of mistrust at the presence of missionaries, relating that they did not know what the missionaries had come to do or what their goals were in working in Tanzania. Two people, both of whom work with AM missionaries on an almost daily basis, even directly mentioned being suspicious that they were being spied on. One upper-level staff member working for the AIC elaborated, telling me that he felt that there was a significant barrier between

missionaries and the local population due to a lack of communication and of local people who trust them and who could potentially serve as a liaison between the two groups.

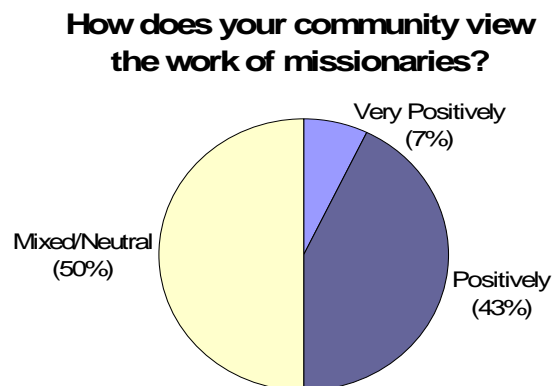
I wanted to survey residents of Geita to discover what common perceptions are about why missionaries come to Tanzania. Participants in my study were given a list of possible choices from which to select as many answers as they thought were applicable. The most commonly-selected responses were that missionaries had moved to Tanzania to help others and to teach people about God, with ten and eleven responses respectively. These answers correlate with the data collected about what the job of a missionary is and what tasks they are seen performing most often.

However, many respondents had a difficult time choosing their answer, some again stating their lack of knowledge as to what missionaries aim to accomplish. Two people said that they believed missionaries came to earn money, both of whom were again upper-level staff members of the AIC. One man I spoke with seemed to have a generally high opinion of missionaries, yet he said he believes they often move to a third-world country to be able to have a lifestyle that they could not afford in their home countries. He said one motive for their work was to be able to “live like rich people” in a poor country.

Throughout the course of my interviews, I heard similar sentiments from other community members, although not necessarily in response to a particular question. Another man told me that he found missionaries to be hypocritical because they do not follow the “Golden Rule” that Jesus speaks of in the Bible of doing unto others and you would have them do unto yourself. He complained in particular of the abundance of missionaries being a hindrance to building positive relationships between two cultures because of the complete lack of affluence of nearly every other individual living in Geita. As Mr. Kroppach admitted, “We must look very rich in their eyes. Money never dries up. [We have] a big house where three families instead of one would easily have room. The car is always ready to go with diesel.”

In order to gain an understanding of how the opinions of residents about the presence and work of missionaries in Geita, I asked the community members I surveyed to rate both their individual view of missionaries and how they believe the community as a whole perceives missionaries. I found asking both questions to be valuable because I hoped it would encourage people to be more honest when talking about the views of others than they might if they were only discussing their own opinions.

For the question about personal views of missionaries, “very positively,” “positively,” and “mixed or neutral” each received four responses, and one person said that they viewed missionaries “negatively.” Two people did not answer the question because they did not feel that they had enough information about missionaries’ goals in Geita to properly judge their work. On average, individual opinions were slightly more positive than how people said their community as a whole views missionaries; only one person answered that the community at large in Geita views missionaries “very positively,” six people felt that “positively” was the most accurate answer, and seven responded with “mixed/neutral.” There was only one omission, again on the same ground that was given for not answering the previous question.



In general, I found that while people living in Geita could fairly easily answer my initial question that required them to define the term missionary and could identify who they were in Geita, when questioned further on the subject, most seemed confused about or

suspicious of the work that missionaries are currently doing in the region. The sampling of the local population that I surveyed oftentimes did not understand what work was being done or what the driving motives behind it were, and all of these people interacted with missionaries frequently. It would logically follow, then, that the majority of the population would have even less knowledge about their work.

The most commonly-expressed points of tension between the cultures of the missionaries and of the local population involved money and a lack of transparency on the part of the missionaries in making their objectives and goals known to the community. There seemed to be a general expectation on the part of the Tanzanians that the missionaries would be preaching the gospel of Christianity and proselytizing, but neither the Kroppachs nor the other German missionary in Geita actively engage in evangelism, especially not within the context of formal church gatherings or services. The disconnect between expectations and reality likely plays a very significant role in the lack of trust expressed between the local population and missionaries. This does not, however, necessarily imply that the local community would welcome missionaries who actively preach and plant churches; their responses are likely based upon their historical knowledge and upon common stereotypes of what missionaries do. These results demonstrate a need for improved efforts to bridge the communication gap between the two groups. Such an effort could perhaps be effectively implemented through a community-based program such as the SHGs that the Kroppachs are beginning to develop.

When I questioned the Kroppachs about the priorities of their work in Geita and the importance they place on evangelism and developmental aid, they both said that while the two aspects of mission work are inseparable, they are primarily focused on bringing development aid to Geita. Their emphasis on helping people to help themselves, as the motto of SHGs goes, stems from a belief that the AIC is an established religious body that is able to teach about God and lead the Church on its own. However, because the AIC has not been able to

affect major changes in the poor material or social conditions of its members, the Kroppachs and AM believe that their efforts should be directed to aiding in the area of development.

The Kroppachs believe that using Christian ethics as foundational principles of the SHGs will strengthen the groups, but he does not perceive that direct evangelism, especially preaching to large numbers of people, should be an important part of their ministry. In their opinion, that should be left to the Tanzanians themselves. In fact, of the five AM missionaries working in western Tanzania, only one occasionally engages in religious instruction. Mr. Kroppach told me that when they are hosting public seminars such as the ones I attended on safe drinking water and personal hygiene, their religious background is always underlined as the motivation for doing their work. This holds true for all work that they engage in, whether it be developing SHGs or through building relationships with individuals. He also said that while they never want to pressure anyone into becoming a Christian, communicating the message of Christianity, whether it be through words or actions, is the reason that he and his family moved to Tanzania.

## **Conclusion**

My research reveals that in both case studies, contemporary German mission work in East Africa tends to place a much greater emphasis on community-based aid than it has in the past. To effectively deliver this aid, a great deal of importance is placed on fostering community support of projects operating in East Africa and on sponsoring partners who train leaders from within the local population. In addition, my data and observations suggest that German mission organizations are beginning to operate under the assumption that community-based work is more sustainable and effective than when carried out by foreigners. Another important factor that seems to play a role in how contemporary German missions determine to structure their work is the progression of partners towards financial independence from – or at least reduced dependence upon - international monetary support. These values are clearly



reflected in the goals and guiding principles of the German umbrella organizations that sponsor international partner projects, and they seem to increase trust and acceptance between the mission and the local population.

The sponsorship of both KDEC and GRC by their respective German umbrella organizations can be seen as an outworking of the faith-based foundations or affiliations of those organizations, yet the degree to which the message of that faith manifests itself in their work varies. In general I found that German missions stress the necessity of development aid to a much greater extent than they do the need for evangelism. The specific type of work being done at each organization varied; GRC tends to promote development aid via local networking and self help groups that nevertheless have a Christian message tied to them, while KDEC brings improved healthcare to the Kwale District without any religious strings attached.

Although this is not the intent of the Medical Director at KDEC, the charitable work of the eye clinic could be seen by others – specifically by CBM - as a kind of quiet evangelism. Because helping the poor is an important part of the teachings of Christianity, KDEC's provision of eye care services to the impoverished population of the Kwale District continues to encourage financial support from CBM. The same concept holds true for GRC and its sponsorship by AM, although in their case the clear affiliation the Kroppach family has with the AIC and the fact that they are known in the community as missionaries means that most people are aware at least of the fact that they are Christians. It is improbable, however, that neither KDEC nor GRC would procure many funds from their international support networks without clearly demonstrating that their work is community-based.

An excellent example of steps an organization can take to extend leadership to members of the local community is KDEC's policy of hiring a diverse group of staff members regardless of religious background. The fact that all but two of the clinic's fifty-one employees are Kenyan is a reflection of its commitment to engaging with the communities in

the Kwale District area in a way that empowers the population. KDEC's strong belief in its Community-Based Programme is another indicator of this dedication. The successes of this program can be measured indirectly by the growth in patients seen and operations performed at the Eye Centre over time and the positive way in which community members rated their experiences with the clinic's treatment and staff. This reveals a trust between the community and KDEC that was certainly not present when it opened its doors in 1993.

Interviews with staff and patients, observations made during visits to the Eye Centre and to the field, and information available to the general public on CBM's international website indicate that spreading religion is not the most important factor in deciding which projects to support. An analysis of the operational practices and organizational structures at KDEC when used as a case study provides insight into how this German mission organization determines where to focus its resources. My research provides evidence that CBM's support of partner projects like KDEC is largely contingent upon continual progression toward independence from international financial aid and foreign staff support as well as the effectiveness of an established community-based program rather than on factors relating to directly spreading religion.

KDEC's emphasis on being community-based is mirrored by CBM's commitment to becoming increasingly more ethnically and religiously inclusive. The effort to increase diversity affects not only the people it serves, but it also has a major organizational impact by developing diversity in its leadership on an international level. Because CBM focuses its efforts primarily on development aid rather than on evangelism, their organization sponsors religiously-based hospitals and clinics as well as projects such as KDEC which in fact do not encourage discussion of religion between patients and members of staff. Such practices demonstrate a clear departure from past precedents in German mission work in East Africa in which a greater focus was placed on religion and on cultural tolerance rather than cultural acceptance. These changes have been made to increase the sustainability and effectiveness of

the individual partner projects, and by using KDEC as a case study, it would appear that this is being done with impressive success.

Unlike CBM, AM does not partner with local projects that are already in motion; rather, it plans projects that it would like to establish and then hires missionaries to set them in motion. On average, it places a much greater emphasis on Christianity in the execution of its projects, yet even a church-planting organization like AM has also begun to diversify its services to include projects that place a much greater emphasis on development or humanitarian aid than on evangelism. The GRC is such a project; although the Kroppachs were motivated to work in Tanzania at least in part by religion, their relationship with the AIC does not necessarily imply that they have the ability to make organizational decisions within the church or to determine how the church should be led or which doctrines should be preached. In fact, they do not desire to engage in conventional religious teaching and proselytizing; instead, the Kroppachs are much more intent upon bringing sustainable development to Geita. They are focusing their efforts and building up SHGs dedicated to helping people help themselves, a project that will ultimately be led exclusively by residents of Geita.

Because they have only recently begun official work on this project and are still developing the community-based aspect of it through hiring and training local leadership, community members were in general much less trusting of the presence of foreigners than were members of the local population in the Kwale District about KDEC. Many Tanzanians I spoke with expressed a desire for better communication between themselves and the missionaries and wished for an explanation of the missionaries' goals and purpose for having come to live in Geita, revealing the need for leadership that Geitans could recognize and more easily accept. As work begins to get underway and the GRC starts to function as a resource to the community, the Kroppachs hope to be able to build the trust of the local population by striving to become more community-based.

The movement towards emphasizing humanitarian aid rather than evangelism in German missions work cannot be attributed to any single factor. One avenue that could be explored in explaining the increasing emphasis placed on humanitarian aid is the exponential growth of the role of technology and media in procuring funds from donors and the need for missions organizations to engage in highly visible work. Competition for funding with an increasing number of secular charities may also play a role in the trend of German missionaries to diversify and expand their focus to include more development aid. The differences in projects sponsored by umbrella organizations that belong to the *Landeskirchen* (state churches) as opposed to missions funded by *Freiekirchen* (independent churches) could also provide another dimension in the discussion on what kinds of projects certain organizations decide to sponsor. An additional factor could be the era of privatization of support in the global South, particularly in health and social sectors, that was ushered in by the end of the Cold War and has left development NGOs with a void to fill, perhaps encouraging German missions to shift their focus away from evangelism (Debiel and Sticht).

This study identifies trends in the degree to which sustainable, community-based development aid characterizes German missions and that this priority is growing in importance within the umbrella organizations that sponsor individual projects. While it seems that German missions have effectively transferred ecclesiastical control of church leadership to the local population, the transition process of placing power in the hands of local communities to lead efforts in self-management of development aid has only recently begun to gain momentum. The movement towards a localization of leadership of mission projects is evident in both of the individual organizations I researched and in the umbrella organizations that sponsor them, yet it must also be noted that the highest positions of leadership are still not being transferred to East Africans. Additional research is necessary to be able to discern the degree to which these results can be projected onto German missions as a whole and where these trends fit within the global scope of mission work.

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**APPENDIX 1: KDEC STAFF QUESTIONNAIRE**

Health facility, Country:		Date:
Position (e.g. nurse, doctor etc.):		
Q1	Do you consider your clinic or mission to be a Christian-based organization?	Yes No
Q2	In what year was your clinic or mission founded?	Year: _____
Q3	What is your organization's mission statement? (record below)	
Q4	How much time per day do you spend with patients (directly)?	Hours: _____
Q5	Do you normally inform a patient receiving sponsored treatment that a portion of the funding comes from a Christian organization?	Yes No
Q6	How often do you pray with each of the patients your organization serves?	Always Often Sometimes Rarely Never
Q7	How often do you discuss Christianity with the patients your organization serves? (if you answer "Never", go on to Q9)	Always Often Sometimes Rarely Never
Q8	Of these discussions, how often are they initiated by you personally?	Always Often Sometimes Rarely Never
Q9	Are members of staff with direct patient contact given specific instructions about whether or not to discuss religion with patients?	Yes No

Q10	If so, are they more encouraged or discouraged from initiating conversations about religion?	Encouraged
		Discouraged
Q11	Do you consider yourself a Christian?	Yes
		No
Q12	Do you consider your organization to be community-based?	Yes
		No
Q13	How important is it for your organization to work with and train local members of the community?	
		Very Important
		Important
		Not Important
Q14	How well do you feel your organization is received by the local community?	
		Very well
		Well
		Neutral/Mixed
		Poorly
		Very poorly
Q15	What is/are the predominant religious group(s) in your area or district?	
		Muslim
		Christian
		Other: _____
Q16	Do you feel that discussing religion with patients is beneficial to your clinic or mission? Why or why not?	Yes
		No
		Reason:



**APPENDIX 2: KDEC PATIENT QUESTIONNAIRE**

Location:		Date:
Language interview is conducted in:		
Q1	Are you now or have you been a patient at the Kwale District Eye Centre? (If No, skip to Q4)	Yes (1)    O
		No (2)    O
Q2	Would you recommend the services of KDEC to a family member or close friend?	Yes (1)    O
		No (2)    O
Q3	How would you rate your experience with the treatment you received from KDEC?	Very good (1)
		Good (2)
		Neutral (3)
		Bad (4)
		Very Bad (5)
Q4	How did you first hear about KDEC? (if other, who?)	Friend (1)
		Family (2)
		Community Member (3)
		Other (4)
Q5	How do you think your community views KDEC? (very positively, positively, mixed/neutral, negatively, very negatively)	Very Positively (1)
		Positively (2)
		Mixed/Neutral (3)
		Negatively (4)
		Very Negatively (5)
Q6	How would you rate your experience with the staff and volunteers of KDEC? (very good, good, neutral, bad, very bad)	Very Good (1)
		Good (2)
		Neutral (3)
		Bad (4)
		Very Bad (5)
Q7	Did you visit a traditional healer or use traditional medicines for your eyes before coming to KDEC?	Yes (1)    O
		No (2)    O
Q8	What is your religious background? (Christian, Muslim, other)	Christian (1)
		Muslim (2)
		Other (3)
Q9	Do you know any of the groups or organizations who sponsor the work done at KDEC? If so, who?	Muslim (1)
		Christian (2)
		Other (3)
Q10	Which religious group do you believe is one of KDEC's biggest sponsors? (if other, which group?)	Christian (1)
		Muslim (2)
		Other (3)

### APPENDIX 3: GRC QUESTIONNAIRE

Date:

Language:

Questionnaire Number:

- 1) How would you define the term “missionary”?
- 2) How often do you have contact with missionaries?
  - a) 0-1 times/year
  - b) 2-5 times/year
  - c) 6-12 times/year
  - d) Daily or weekly
- 3) What is the job of a missionary? (Select all that apply)
  - a) Get to know people in the local community
  - b) Pay for improvements needed in the community
  - c) Teach people about religion and God
  - d) Teach people how to improve their lives or community
  - e) Give people money who have needs
- 4) Which do missionaries do most often?
  - a) Get to know people in the local community
  - b) Pay for improvements needed in the community
  - c) Teach people about religion and God
  - d) Teach people how to improve their lives or community
  - e) Give people money who have needs
- 5) Which do missionaries do least often?
  - a) Get to know people in the local community
  - b) Pay for improvements needed in the community
  - c) Teach people about religion and God
  - d) Teach people how to improve their lives or community
  - e) Give people money who have needs
- 6) How do you personally view the work of missionaries living in Geita?
  - a) Very positively
  - b) Positively
  - c) Mixed/Neutral
  - d) Negatively
  - e) Very Negatively
- 7) How do you think your community views the work of missionaries?
  - a) Very positively
  - b) Positively
  - c) Mixed/Neutral
  - d) Negatively
  - e) Very Negatively

- 8) Who do you think pays for missionaries to live and work in Tanzania?
- a) Tanzanian government
  - b) Foreign governments and/or organizations (non-religious)
  - c) Missionaries themselves
  - d) Rich people from foreign countries
  - e) Christians and churches
  - f) Muslims
- 9) Why do you think missionaries come to Tanzania? (Select one)
- a) Because they like Tanzania
  - b) To live in a new place
  - c) To help others
  - d) To earn money
  - e) They want to teach people about God
- 10) Which religious group do you belong to, if any?
- a) Christian
  - b) Muslim
  - c) Other
- 11) What is your occupation?
- 12) How long have you lived in Geita?
- a) 1 year or less
  - b) 2-5 years
  - c) 5+ years